COMMENTS

STANDING TO SUE: EXTENDING THIRD-PARTY STANDING TO PHYSICIAN-PROVIDERS TO ENFORCE THE MEDICAID ACT

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† St. Mary's University School of Law, Candidate for J.D., May 2006; Stanford University, B.A. Public Policy, June 2001. To Tracy, I love you, you are the pillar of my strength. Thank you for wanting to marry me. The author wishes to thank his mother for her enduring spirit as a strong Chicana role model balancing her career and her family. Likewise for my father for instilling in me the value of empowerment through education, you are my greatest teacher. To my *carnales* who continue to inspire me by living as great men. To my nieces Sofia and Karyssa and my nephew Robert Jr., may we remember to dedicate our lives to the services of those who serve us.

"In my view, the border's been shortchanged for decades. In my view, that is rank discrimination against Hispanics, institutionalized state government discrimination against Hispanics."[1]

These words from Texas State Senator Elliot Shapleigh reflect the historical trend of communities along the Texas-Mexico border, receiving only the proverbial scraps of state assistance from the state legislature.[2] Although there are various federal and state aid programs which provide assistance, the pervading sentiment is that the border is not receiving its full entitlement to government appropriations and that new aid should be created to completely address those needs. This comment concerns itself with the Medicaid Act and, more specifically, the manner in which the State of Texas administrates the program. Currently, the federal program aimed at alleviating the plight of the indigent is operated in such a way that it perpetuates a disparate impact upon border cities.[3] Texas counties that operate with a budget shortfall are now left with the overwhelming burden of supporting indigent patients who are incapable of securing private healthcare coverage and have been denied the ability to rely on Medicaid for necessary medical attention.[4]

Political rhetoric frequently pollutes the media with false promises of hope for greater attention toward issues specifically affecting border communities; however, change is never effectuated and the state legislators always fall short of great expectations.[5] For example, in January 2001, immediately after succeeding George W. Bush as Governor for the State of Texas, Governor Rick Perry remarked, "There is strong bipartisan rec-

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1. Polly Ross Hughes, *78th Legislature; The Budget; Ok'd Bill Cuts Some Services; Taxes Won't Rise*, HOUSTON CHRON., June 2, 2003, at A13.

2. *Id.*; *Community Mental Health Funding: Hearing Before the Tex. House Appropriations Subcomm. on Health and Human Services*, 78th Leg. (2003), http://www.epcounty.com/CA/mhmrtest.htm (statement of Jose Rodriguez, El Paso County Attorney).

3. Diana Washington Valdez, *Medicaid Rules Prompt Suit*, EL PASO TIMES, Dec. 13, 2003, at B1 (arguing that tax payers will be forced to pay higher taxes to provide additional funding to the hospital district given that absent preventive healthcare, the indigent sick will be forced to seek medical services in the emergency room once their condition becomes severe); *see also Medicaid Reimbursement: Hearing Before the Tex. Senate Comm. on Health and Human Services*, 77th Leg. (2001), http://www.epcounty.com/CA/health&humanservcomit.htm (statement of Jose Rodriguez, El Paso County Attorney) ("Disparate state funding forces tax increases upon an already burdened tax base and for the Medicaid and CHIP populations, it perpetuates lack of access to health care and needed medical facilities.").

4. Valdez, *supra* note 3; *see also* Op-Ed, *Passing It On; Pay Now in Texas Budget or Pay More Locally*, HOUSTON CHRON., May 11, 2003, at Outlook2.

5. W. Gardner Selby, *Promises for Border Not Fulfilled; House Leadership Blocks $250 Million Plan as Legislature Winds Down*, SAN ANTONIO EXPRESS-NEWS, May 27, 2001, at A1.

ognition that the border has real needs that must be addressed. There is no better time than now to roll up our sleeves and get to work."[6] That year, there were numerous proposals to assist the border with transportation dollars, education dollars, healthcare dollars and other infrastructure funding; the plans, however, never materialized.[7] Instead, just the opposite occurred when the governor spearheaded the proposed six percent reduction for the 2003-2004 biennium Medicaid budget.[8] Similarly, the governor's thoughts as to the State Children's Health Insurance Program ("CHIP")[9] have also changed.[10]

The effect of that policy decision forces over 2.5 million Texans, the number of individuals enrolled in the Medicaid program as of February 2004, to the brink of losing their benefits.[11] Medicaid recipients in Texas are dependent upon physicians' discretion to provide medical services.[12] At the same time, the healthcare services industry is witnessing the flight of doctors from the border to other, more affluent suburbs in Texas.[13] Thus, Medicaid recipients living among the United States-Mexico border communities are forced to endure the ramification of budgetary cuts to an even greater extent than those living in non-border communities.

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6. *Id.*

7. *Id.*

8. Gary Scharrer, *Medicaid Cuts Could Harm El Paso Area*, EL PASO TIMES, Feb. 17, 2003, at A1; Leigh Hooper, *Doctors: Cutting Health Funds is Not the Answer; Slashing Budgets Puts Burden on Hospitals, Group Argues*, HOUSTON CHRON., Apr. 30, 2003, at A25 (describing the House budget's approval of cutting 250,000 children from CHIP and 56,000 elderly and disabled persons under Medicaid); *see also* IAN HILL, STATE CASE STUDY: MEDICAID AND THE 2003-05 BUDGET CRISIS – A LOOK AT HOW TEX. RESPONDED 2-3 (2005), http://www.kff.org/medicaid/7324.cfm.

9. State Children's Health Insurance Program, 42 U.S.C.A. § 1397aa (2000); *see also* TEX. HEALTH & SAFETY CODE ANN. § 62.001 (Vernon Supp. 2004-2005) (providing that the purpose of CHIP is to subsidize health insurance for children of working-poor families who cannot afford the cost of private health insurance providing preventive healthcare to children who are not eligible for other aid).

10. Peggy Fikac, *Perry Re-Thinks Kids' Coverage; He Says Cutting Them from CHIP Won't Hurt Emergency Rooms*, SAN ANTONIO EXPRESS-NEWS, May 21, 2003, at A6 (citing that Governor Perry no longer believes that cutting eligible CHIP recipients from the program will lead them to the emergency room to seek medical attention).

11. TEX. HEALTH AND HUMAN SERV. COMM'N, TEXAS MEDICAID IN PERSPECTIVE 1-1 (5th ed. 2004), *available at* http://www.hhsc.state.tx.us/Medicaid.

12. *See* Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 AM. J.L. & MED. 191, 201(1995) ("No state requires physicians, as a condition of participation in Medicaid, to accept all enrollees who request care.").

13. Diana Washington Valdez, *Thomason Sues State: Medicaid Reimbursement Rates Are Target*, EL PASO TIMES, Oct. 25, 2003, at A1.

Admittedly, legislators intended for the Medicaid Act to provide indigent persons adequate medical services.[14] Unfortunately, the State of Texas currently fails to administer the Act equitably across the state. Physicians practicing in communities on the United States-Mexico border and inner-city areas are reimbursed for medical services provided to Medicaid recipients at a lower rate than those practicing in other areas of Texas.[15] Compare the rate of reimbursement for delivery of a baby; on average, a doctor in Houston receives $634 while a doctor in El Paso will receive only $450 for the same medical procedure.[16] That is, the amount of reimbursement is not dependent upon the medical procedure, but rather the city in which the services were procured dictates the value of the medical care. Consequently, this system has adversely affected the Medicaid program so that Texans may or may not have readily-accessible medical care. Instead of providing a reliable healthcare system, Texas operates an inequitable assistance program.[17]

As stated above, due to the state's reimbursement schedule, physicians are fleeing border communities to other areas in Texas where there are lower numbers of Medicaid patients.[18] As a direct consequence, the existing Medicaid patients have fewer numbers of physicians to provide medical care. In El Paso alone, this exodus has produced results such that the city "has sixty-one percent more patients per doctor than the statewide average."[19] If these physicians were equitably reimbursed by the state, they would not relocate from underserved geographical areas.

Public policy decisions implementing Texas' Medicaid fee schedule have caused the Texas Medical Association to issue a formal recommendation to physicians that they limit their number of Medicaid patients in order to avoid bankruptcy.[20] Thus, public policy decisions which further limit Medicaid spending, in effect, create a disincentive for physician-providers to treat Medicaid beneficiaries because they will not be equitably reimbursed for those services. Within the near future, patients will be

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14. *See* Watson, *supra* note 12, at 195 (describing the history of "dual-track" medical care in the United States).

15. Valdez, *supra* note 13.

16. *Id.*

17. *See* Watson, *supra* note 12, at 198 (citing the fact that historically, inner cities and rural areas have less access to Medicaid physicians, and those physicians who remain do so under great strain to provide medical care to the uninsured and Medicaid patients).

18. Valdez, *supra* note 13.

19. *Id.*

20. Luis Figueroa, Note, *A Legal Analysis of the Texas Medicaid Reimbursement-Scheme and its Effects on the Border Region*, 9 TEX. HISP. J.L. & POL'Y 55, 62 (2003) (citing Jim Yardley, *A City Struggles to Provide Health Care Pledged by U.S.*, N.Y. TIMES, Aug. 7, 2001, at A1).

refused preventive medical care from all healthcare providers who will decline to participate in the Medicaid program.[21]

A problem exists in Texas. Texans are not receiving equitable medical attention without regard to the city in which they live.[22] Any inequitable distribution of reimbursement rates violates the Medicaid Act, specifically section 1396a(a)(30)(A), which mandates that the state administrate the program in an equitable manner that ensures that all Texans receive their healthcare entitlements regardless of the location of their residence.[23] A remedy must be implemented to cure this wrong. Although physicians once had a recognized cause of action, the legislature repealed the Boren Amendment to the Medicaid Act.[24] Currently, physicians have no such recognized cause of action against the state. Therefore, Texas Medicaid recipients are left to defend themselves. Allowing physicians to assert a claim on behalf of Medicaid beneficiaries to enforce the Medicaid Act would provide for a legal remedy to this problem.

This comment advocates for the right of physicians to assert constitutional rights on behalf of indigent patients in an action against the State of Texas for equitable reimbursement rates under the Medicaid Act. Part I of this comment explores the legislative intent and history of the Medicaid Act, in an attempt to understand its purpose in providing healthcare coverage to the poor of the nation. Part II examines the current condition of healthcare coverage, both private and public, available within the State of Texas. This assessment also delves into the extrinsic effects of an existing populace living without healthcare coverage. The final section is an analysis of previous legal attempts to secure equity in Medicaid. In conclusion, this comment advocates for the right of physicians to invoke the constitutional protection of Medicaid recipients who lack the resources to assert those rights on their own behalf.

I. INTRODUCTION

The Medicaid Act was established by Congress in Title XIX of the Social Security Amendments of 1965.[25] The purpose of the Act was to pro-

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21. *See* Watson, *supra* note 12, at 191 (arguing that physician self interest should be used to condition access to middle-income patients as an inducement for physicians to treat Medicaid beneficiaries).

22. *See Community Mental Health Funding, supra* at note 2 (giving testimony on the heavy impact of disproportionately low reimbursement rates on the county health district).

23. 42 U.S.C. § 1396a(a)(30)(A) (2004).

24. *See generally,* Malcolm J. Harkins II, *Be Careful What You Ask For: The Repeal of the Boren Amendment and Continuing Federal Responsibility to Assure that State Medicaid Programs Pay for Cost Effective Quality Nursing Facility Care*, 4 J. HEALTH CARE L. & POL'Y 159 (2001); Figueroa, *supra* note 20, at 70.

25. 42 U.S.C. § 1396.

vide healthcare services to low-income persons.[26] The benefits were established as an entitlement program.[27] The cooperative program is "jointly financed by the federal and state governments;" the federal government provides matching funds to augment state government funding.[28] Participation is voluntary, but once a state chooses to join, the Act mandates strict compliance with its regulations for administering services.[29] The participating state must submit a proposed plan for approval to the Secretary of Health and Human Services.[30] The funding scheme does not provide monies to the individual recipients. Instead, payments are made directly to healthcare providers by the state through reimbursement for medical services.[31] That is, although the Medicaid recipients are the beneficiaries of the Act, the physician-providers receive direct benefits through state reimbursement.

The Medicaid Act has provided millions of poor and near-poor recipients with the opportunity to receive medical attention. Additionally, the Medicaid Act has produced a dramatic economic benefit for the healthcare industry. In 2004, federal and state dollars combined to a total of $305 billion and provided medical coverage for fifty-two million people.[32] In that same year, funding of the Medicaid Program accounted for one-fifth of all money spent on healthcare in the United States.[33]

While the federal government provides funding to the states for distribution, federal law allows those states to establish their own rate of reimbursement.[34] Therefore, the administration of the Medicaid Act varies from state to state. For example, Texas joined the program in September 1967 and created a task-force under the Texas Department of Health and Human Services Commission ("Commission") for the sole purpose of establishing such rate-setting methodologies.[35] In Texas, the Commission is charged with the responsibility of administering Medicaid to needy persons who qualify for such aid.[36] The problem being addressed in this

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26. 42 U.S.C. § 1396.

27. KAISER COMM'N ON MEDICAID AND MEDICARE, MEDICARE & MEDICAID AT 40: KEY MEDICARE AND MEDICAID STATISTICS 2004 6 (2005), http://www.kff.org/medicaid/40years.cfm.

28. Public Health Medical Assistance Programs, 42 C.F.R. § 430.0 (2004).

29. 42 U.S.C. § 1396a.

30. 42 U.S.C. § 1396a.

31. 42 C.F.R. § 430.0; Figueroa, *supra* note 20, at 57.

32. KAISER COMM'N ON MEDICAID AND MEDICARE, *supra* note 27, at 2.

33. *Id.* at 8.

34. 42 U.S.C. § 1396a.

35. TEX. GOV'T CODE ANN. § 531.0221 (Vernon 2004); *see also,* CAROL KEETON STRAYHORN, TEXAS HEALTH CARE CLAIMS STUDY I-8 (2003), http://www.window.state.tx.us/specialrpt/hcc2003/96-787.pdf.

36. STRAYHORN, *supra* note 35, at I-7.

comment arises when the rates of reimbursement are inequitably distributed within the state. This problem originated when the Commission established an inequitable method of determining rates of reimbursement.

The cause of action central to this comment is based on section 1396a(a)(30)(A) of the Medicaid Act. This section mandates equity in the methodology of administering the Act.[37] The section, amended by Congress in 1989, requires a state to:

> Provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan. . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.[38]

This provision, known as the Equal Access Clause, has provided a successful claim for Medicaid recipients to assert their rights under the Medicaid Act. In fact, the United States Court of Appeals for the Fifth Circuit, in *Evergreen Presbyterian Ministries, Inc. v. Hood*[39] acknowledged that the Equal Access Clause of section 1396 provided a valid cause of action for Medicaid beneficiaries.[40] Therefore, a legal remedy already exists. This comment builds upon the precedent established by *Evergreen*. While other articles and comments discuss the search for a legal remedy[41] to address inequitable rates of reimbursement, the Medicaid Act itself explicitly provides a cause of action to pursue when seeking enforcement of its policies. Therefore, this comment does not advocate for the creation of a new cause of action. Instead, it suggests that physician-plaintiffs utilize the *Evergreen* analysis to assert third-party standing. Although the cause of action in *Evergreen* is apparently available, a latent defect creates a very serious obstacle: the same beneficiaries who lack resources to receive medical attention also lack the necessary resources to reach the judiciary, making recovery unlikely, if not impossible.

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37. 42 U.S.C. § 1396a(a)(30)(A) (stating service must be equally accessible to the same extent that it is accessible to the general population in the same geographic area).

38. § 1396a(a)(30)(A).

39. Evergreen Presbyterian Ministries, Inc. v. Hood, 235 F.3d 908 (5th Cir. 2000).

40. *See generally Evergreen*, 235 F.3d 908.

41. *See generally* Figueroa, *supra* note 20; Marlaina S. Freisthler, Comment, *Unfettered Discretion: Is Gonzaga University v. Doe a Constructive End to Enforcement of Medicaid Provider Reimbursement Provisions?*, 71 U. CIN. L. REV. 1379 (2003).

A. *Healthcare Insurance Coverage*

Prior to addressing this problem with the Medicaid Act, it is important to understand the underlying need for the healthcare entitlement program. Studies demonstrate a direct correlation between socio-economic status and healthcare insurance coverage.[42] Specifically, when comparing individuals by socio-economic status, persons with lower income are less likely to have health insurance when compared to their higher-earning counterparts. Statistical data also reflects a direct correlation between healthcare insurance coverage and access to medical services. Thus, persons with some form of health insurance, public or private, have higher rates of receiving medical attention than those persons who lack any sort of health insurance.[43] Moreover, individuals without healthcare coverage are "less likely to have a regular source of care, more likely to have delayed or forgone needed care, and less likely to have seen a physician during the year."[44] That is, the uninsured receive less medical attention than those that are underinsured, and to an even lesser degree when compared to individuals with private health insurance.

Essentially, individuals with insurance have access to preventive care, and are not forced to postpone treatment. Those individuals who do postpone treatment will eventually be left with the only alternative: seeking emergency medicine, undoubtedly the most expensive form of medical attention. Uninsured individuals are faced with "serious consequences that increase their chances of preventable health problems, disability and premature death."[45] Although it appears that the decision to postpone treatment will only affect the health of the uninsured individual, the ramifications are far-reaching and the burden is spread to all people across this nation.

This disturbing pattern of inequitable medical care access and utilization poses serious, harmful consequences for the physical and fiscal health of the nation. Dr. Fred Ciarochi, president of the Dallas County Medical Society, issued a statement regarding the adverse effects upon the health of society in relation to postponing medical treatment, stating that "putting off the treatment of illnesses in early stages only increases costs later, when diseases have grown more serious and must be ad-

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42. *See* E. RICHARD BROWN, ROBERTA WYN & STEPHANIE TELEKI, DISPARITIES IN HEALTH INSURANCE AND ACCESS TO CARE FOR RESIDENTS ACROSS U.S. CITIES (2000), http://www.healthpolicy.ucla.edu/pubs/pubList.asp (examining access to health insurance coverage in eighty-five metropolitan areas).

43. *Id.* at 15.

44. *Id.* at 19.

45. KAISER COMM'N ON MEDICAID AND THE UNINSURED, MYTHS ABOUT THE UNINSURED FACT SHEET 2 (2005), http://www.kff.org/uninsured/7307.cfm.

dressed."[46] In the same article, Dr. Ciarochi highlighted the ramifications upon local county budgets: "Every taxpayer ought to understand that reduced access has been shown to be a dangerously false economy in health care."[47] Reducing preventive care as a means to decrease budgetary spending only shifts the financial burden onto the budgets of emergency medicine.[48] In other words, money spent on preventive healthcare reduces the likelihood of people seeking more costly emergency medical care in the future. Furthermore, the reverse is also true; the less the state spends to keep a healthy population, the more it will spend on its populace at its emergency rooms across the nation.

Survey research involving national data compilation is not without its errors, but a careful analysis allows for reporting with the caution that the reader needs to have an understanding of the results. For example, the United States Census Bureau conducts numerous different surveys, one of which involves healthcare coverage for the population. However, the Census Bureau recognizes the intricacies and shortcomings of different types of surveys conducted. To remedy the discrepancies in information, a report was issued that compared two separate studies: "People with Health Insurance: A Comparison of Estimates from Two Surveys."[49] That report examined the data collected through the Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC) and the Survey of Income and Program Participation (SIPP). In order to find the most accurate representation of the population size living with some form of health coverage, the report examined and compared the two Census surveys, looked at the similarities and differences in the times covered during each year, and lastly, took into account the sample number of participants.[50] It is important to note that the data results reflecting government-based healthcare coverage tended to be more accurate than those demonstrating private coverage.[51]

Medicaid serves as a safety net for individuals without private healthcare coverage. For the year 2001, the Census Bureau reported that slightly more than twenty-five percent of the nation's population was cov-

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46. Fred Ciarochi, Letter to the Editor, *Parkland Budget; County Must Approve Tax Rate Increase to Safeguard Community's Health*, DALLAS MORNING NEWS, July 23, 2000, at J6.

47. *Id.* (Dr. Ciarochi, president of the Dallas County Medical Society issued this statement as a plea to increase the tax base to prevent the closing of Parkland's primary-care clinics serving medically underserved neighborhoods).

48. *Id.*

49. Shailesh Bhandari, *People with Health Insurance: A Comparison of Estimates from Two Surveys*, at 3 (U.S. Census Bureau, U.S. Dep't of Commerce, Publ'n No. 243, 2004), *available at* http://www.census.gov/hhes/www/hlthins/reports.html.

50. *Id.* at 3-7.

51. *Id.* at 8.

ered by public health insurance.[52] In 2003, 15.2 percent of the U.S. population, nearly 43.6 million people, were without any form of healthcare coverage.[53] In 2002, 25.8 percent of the State of Texas's population, 5.6 million people, had no health insurance coverage, ranking first in the nation of citizens without health insurance.[54] A total of 3.2 million Texans received coverage through Medicaid; of those, fifty-nine percent were children.[55] Unfortunately, the indigent children of this nation are those most regularly being deprived of healthcare due to budgetary constraints.[56]

B. *Relationship with the Children's Health Insurance Program (CHIP)*

This comment cannot discuss Medicaid without mentioning and briefly explaining the CHIP program. In 1997, Congress enacted 42 U.S.C.A. § 1397aa to address the need of insuring the children of working poor families.[57] The similarities between the Medicaid Act and CHIP has lead Congress to treat the two as a single issue with respect to appropriation committees. Moreover, it is common practice for reports to combine research efforts and publish a single report on both programs. Therefore, discussion of Medicaid financing implicitly involves funding for CHIP. Specifically, section 1397aa(a) of the CHIP statute mandates the provision of financial assistance by either coverage through 1397cc, or "providing benefits under the State's Medicaid plan," or a combination of both.[58]

C. *The Current State of Texas*

Federal financing for the Medicaid program varies from state to state, ranging from between the maximum eighty-three percent and the minimum fifty percent coverage of program costs.[59] In the 2002 fiscal year, Texas was responsible for 39.8 percent while the federal government pro-

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52. *Id.*

53. ROBIN A. COHEN & ZAKIA CORIATY-NELSON, HEALTH INSURANCE COVERAGE: ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY, (Nat'l Ctr. for Health Statistics, Ctr. for Disease Control, 2003), *available at* http://www.cdc.gov/nchs/nhis.htm.

54. TEX. HEALTH AND HUMAN SERV. COMM'N, *supra* note 11, at 2-4, Cover-3.

55. *Id.* at 1-2.

56. Shailesh Bhandari & Elizabeth Gifford, *Children with Health Insurance: 2001*, at 5 (U.S. Census Bureau, U.S. Dep't of Commerce, Publ'n No 60-224, 2003), *available at* http://www.census.gov/hhes/www/hlthins/reports.html.

57. State Children's Health Insurance Program, 42 U.S.C.A. § 1397aa (2004) ("The purpose of this subchapter is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health coverage benefits for children.").

58. 42 U.S.C.A. § 1397aa(a)(2).

59. STRAYHORN, *supra* note 34, at I-8.

vided 60.2 percent of the total funding for Texas's Medicaid program.[60] It is estimated that the total funding for 2002 was $13.7 billion.[61]

Because the Medicaid Act is an entitlement program, neither the federal nor the state government can limit the enrollment numbers "or the amount of money available for services."[62] Once an eligible person has enrolled, the state must expend the monies to cover that person's medical costs. Therefore, any effort to increase enrollment carries with it the burden to appropriate more funds. Unanticipated success of the program's enrollment efforts exceeded budgetary expectations and thus created a budget shortfall.[63] The state did not allocate sufficient funds to cover the actual number of eligible persons for public health insurance, but rather only appropriated funds for an estimated percentage of eligible beneficiaries who were likely to enroll in the program.[64] Ultimately, the state budget shortfall forced the state legislature to implement cost-saving policies.[65]

Estimates by the State Comptroller predicted a shortfall of $9.9 billion for the state of Texas alone.[66] As a result, Texas's total spending for Medicaid and CHIP was drastically reduced for the fiscal year biennium budget 2004-2005 by more than $1.6 billion.[67] At least one report indicates that the dilemma between saving governmental monies and providing adequate appropriations for Medicaid and CHIP is exacerbated because of the operational structure[68] of the Texas legislature.[69] In national comparison, Texas has the lowest rate of employer-sponsored coverage. Therefore, Texas's uninsured are even more dependent upon Medicaid/CHIP for preventive and primary healthcare services than uninsured residents of other states.[70] Even though uninsured residents in Texas had few, if any, alternatives for seeking out health coverage, the subsequent budget cuts included a decrease in the provider reimburse-

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60. *Id.*

61. *Id.*

62. *Id.*

63. HILL, *supra* note 8, at 2.

64. Op-Ed, *CHIP Cuts; Health Benefits for Working Poor Shouldn't be Secret*, HOUSTON CHRON., June 8, 2004, at A22.

65. HILL, supra note 8, at 2.

66. *Id.* at 3.

67. ANNE DUNKELBERG & MOLLEY O'MALLEY, KAISER COMM'N ON MEDICAID AND THE UNINSURED, CHILDREN'S MEDICAID AND SCHIP IN TEXAS: TRACKING THE IMPACT OF BUDGET CUTS 1 (2004), http://www.kff.org/medicaid/index.cfm.

68. TEX. CONST. art. III, § 5 (requiring that the Legislature meet every two years at such time as may be provided by law and at other times when convened by the Governor).

69. HILL, *supra* note 8, at 2.

70. DUNKELBERG & O'MALLEY, *supra* note 67.

ment rates. Doctors and hospitals received a 2.5 percent reduction for fiscal year 2004.[71]

D. *Reimbursement to Providers*

There are "four main healthcare delivery programs" through which Texas Medicaid funding is distributed to physicians: "fee-for-service, managed care services, long term care services and reimbursements to hospitals serving a disproportionate share of low-income persons."[72] Providers are allowed to participate in the program and enroll according to eligibility requirements set by the Claims Administrator, NHIC.[73] This comment addresses the fee-for-service, managed care, and reimbursement-to-hospitals methods for delivering medical attention.

Disparities within the program have not gone unnoticed. The State of Texas commissioned the Health and Human Services Commission to establish the Border Rate Workgroup in 2000, to issue recommendations for alleviating problematic areas within the program.[74] The workgroup concluded and reported its findings in mid-December 2000. The nine-member workgroup made numerous findings and recommendations. Specifically, the report focused on the low number of healthcare providers along the border area, "the effect of access on utilization and the capitation rate methodologies," as well as the reimbursement rates for physicians.[75]

First, the workgroup took issue with the rate methodology used by the state. Specifically, the workgroup noted that the statewide plan failed to "recognize the unique and different health care issues in the border areas."[76] Next, the workgroup noted that the border area suffers from a "disproportionately low number of health care providers including primary care physicians, specialists, registered nurses, pharmacists," and, as a direct result, negatively "impacts recipients' access to services, and consequently, the utilization of services."[77] Likewise, the report finds a di-

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71. *Id.*

72. STRAYHORN, *supra* note 35, at I-8.

73. *Id.* (articulating that there are four contractors that provide support and operational functions for the Texas Medicaid Administrative System. The National Heritage Insurance Company (NHIC) is the current claims administrator which processes Medicaid claims not processed under an arrangement between the state and health maintenance organizations).

74. TEX. HEALTH AND HUMAN SERV. COMM'N, BORDER RATE WORKGROUP FINAL REPORT ON MEDICAID AND CHIP 1 (2000) (on file with author).

75. *Id.*

76. *Id.* at 3.

77. *Id.* at 1-2.

rect relationship between low reimbursement for Medicaid physicians and their decision to avoid practicing medicine in the border region.[78]

The inequities reviewed by the Border Rate Workgroup were addressed and several recommendations were made to improve indigent access to healthcare. The workgroup identified a sixteen percent disparity in the fee-for-service[79] methodology of the program, and recommended a sixteen percent increase to cover that disparity.[80] Likewise, the workgroup suggested an additional ten percent increase specifically patterned after Medicare incentives to physicians who relocate to underserved areas.[81]

Administration of the Medicaid Act has revealed inequities in the manner in which indigent patients are able to receive medical care. The fact that a commission issued the report exposing problematic areas within the program amounts to an acknowledgement on behalf of the state that it is unwilling to make critically-needed changes through the legislative process. Therefore, in keeping with the legislative intent of the Medicaid Act, recipients are left with utilizing the judiciary to enforce the equitable provisions of the Act.

II. HISTORY

Eligibility for Medicaid was initially linked to welfare,[82] in that enrollment was limited to those individuals already receiving aid through the current system of Temporary Assistance for Needy Families (TANF)[83] and of the Supplemental Security Income (SSI)[84] program.[85] However, during the 1980s, Congress expanded enrollment eligibility to individuals who did not qualify for TANF or SSI.[86] The effects of that expansion were significant in allowing low-income individuals, pregnant mothers, and children, among others, access to previously unavailable medical ser-

78. *Id.* at 2.

79. TEX. HEALTH AND HUMAN SERV. COMM'N, *supra* note 11, at G11 ("The traditional health care payment system, under which physicians and other providers receive a payment for each unit of service they provide.").

80. TEX. HEALTH AND HUMAN SERV. COMM'N, *supra* note 74, at 7-8.

81. *Id.* at 8.

82. TEX. HEALTH AND HUMAN SERV. COMM'N, *supra* note 11, at 1-1.

83. *Id.* at 1-1, G1, G27 (TANF is the federal-state cash assistance program for impoverished families, formerly known as Aid to Families with Dependent Children (AFDC). Children who qualify for TANF are also eligible for benefits under Medicaid).

84. *Id.* at G27 ("Supplemental Security Income SSI is a federal program which provides cash assistance to the elderly and disabled poor. It is administered by the Social Security Administration. SSI eligible beneficiaries are automatically eligible for Medicaid benefits in Texas.").

85. *Id.* at G1, G27.

86. *Id.* at 1-1; KAISER COMM'N ON MEDICAID AND MEDICARE, *supra* note 27, at 2.

vices. Unfortunately, the increased enrollment into the program had a negative impact on government finance. As more individuals became eligible to receive aid, state governments, prohibited from refusing coverage to eligible beneficiaries, were required to increase budgetary allocations. Recently, and despite the program's success, the Texas legislature enacted additional administrative enrollment procedures in an effort to decrease the rate at which eligible individuals are accepted into the program. In 2004, the State Comptroller of Texas, Carole Keeton Strayhorn, recommended and implemented the re-enrollment process for eligibility at six month intervals.[87]

The Texas legislature now requires continual re-enrollment of eligible recipients every six months as opposed to every year, and further delays coverage benefits to enrollees for a period of ninety days after initial enrollment.[88] As a result, initial enrollees will not receive any medical attention for three months and immediately thereafter, are required to re-enroll every six months thereafter.

In addition, passage of House Bill 2292 in 2003 by the Texas Legislature modified the enrollment form itself as yet another means to discourage program participation. A description by one journalist described the bill as a deliberate attempt to make the enrollment process "unnecessarily complex."[89] Additionally, the legislation revoked funding for the publicity of the program, effectively hiding the program from the public's attention.[90] The legislature has implemented a difficult enrollment process and requires eligible low-income families to re-qualify with that form every six months while simultaneously reducing efforts to educate the public that the program exists.

The effects of these decisions are undeniable. Within the first month, 6,414 children were dropped from CHIP enrollment, and the decline has continued every month since HB 2292 took effect.[91] As of May 2004, the total state enrollment dropped from 529,211 children to 365,731.[92] Yet, even more startling is the legislature's intent to reduce that number even further. The 2005 budget approved by the legislature will only serve an estimated 347,000 children.[93] It is a sad fact that the Texas Legislature is

87. Robert T. Garrett, *Comptroller's Saving Plan: 'Leaner. . . Not Meaner' Budget Multistate Lottery Pushed; Critics Say Health Cuts Go Too Far*, DALLAS MORNING NEWS, Jan. 11, 2003, at A1; DUNKELBERG & O'MALLEY, *supra* note 67, at 1.

88. DUNKELBERG & O'MALLEY, *supra* note 67, at 1.

89. Carlos Guerra, Op-Ed, *Making People Suffer Goes Beyond Living Within Our Means*, SAN ANTONIO EXPRESS-NEWS, May 25, 2004, at B1.

90. Op-Ed, *supra* note 64.

91. Guerra, *supra* note 89.

92. *Id.*

93. Op-Ed, *supra* note 64.

so willing to deny the children of low-income families medical attention, particularly when the actual cost of the program is so heavily subsidized by the federal government. The federal government contributes seventy-five percent of the costs of the program, leaving the State of Texas accountable for only twenty-five percent of CHIP funding.[94] By reducing the portion of the state's share of appropriations, the legislature is successfully leaving federal funds at the table.

The state representatives who originally drafted legislation making the enrollment process more convenient for indigent clients, argue that eliminating services to those who need them most will have significant ramifications. State Representative Garnet Coleman specifically noted that extended enrollment verification forms place the greatest impact upon the indigent children of the state.[95] While the majority of individual beneficiaries under Medicaid are children, state expenditures on their medical costs consist of only twenty-five percent of the overall Medicaid budget.[96]

Dramatic increases in enrollment also affect healthcare providers. For those healthcare providers located in traditionally, economically-disadvantaged areas, the increased enrollment only exacerbated an already-challenging medical practice. It is unreasonable to expect physician-providers to continue to provide medical assistance and remain in the Medicaid program when their costs are exceeding their reimbursement payments.

Healthcare providers are able to maintain successful practices only with good business plans. Essential to that plan are private-pay patients who can afford to pay for medical services. It is critical for providers to have a payor-mix that can sustain their business and avoid bankruptcy. Regardless of the healthcare coverage's status as public or private, physician-providers who are not adequately reimbursed for the services they provide will eventually be forced out of business. Thus, it is not surprising that many doctors have specifically refused to participate in the Medicaid program.[97] One estimate indicates that one-fourth of the nation's physicians refuse to treat Medicaid recipients.[98] Within Texas, some physicians have announced they no longer accept Medicaid patients, CHIP patients, and even certain private healthcare coverage, primarily because of financial strain.

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94. *Id.*

95. Garrett, *supra* note 87.

96. STRAYHORN, *supra* note 35, at I-10.

97. Watson, *supra* note 12, at 191.

98. *Id.* at 193.

Texas Governor Rick Perry acknowledged the hardship placed upon physicians by the untimely reimbursement rates of private sector insurance companies. Legislation was passed to enforce penalties to private insurance companies who failed to timely reimburse physicians. Governor Perry must now acknowledge the hardships placed upon those physicians whose primary clientele is made up of indigent Medicaid recipients.

A. *Payor-mix and Provider Shortage*

Providers are refusing to treat Medicaid patients because the rates of reimbursement are not sufficient to cover the rising costs of providing services. However, some providers have been able to sustain their practice by simultaneously providing care to patients who can afford to pay their medical bills, either through private insurance or out of pocket. Therefore, it is essential to have an adequate ratio of public and private patients. This ratio is known as the payor-mix.

Texas averages a payor-mix consisting of ten percent Medicaid, and nearly sixty-five percent private insurance coverage, leaving nearly twenty-five percent of Texans uninsured.[99] Estimates for Travis County indicated that sixty-nine percent of patients were private or self-pay, with only five percent on Medicaid.[100] Tarrant County estimates put private coverage at sixty-two percent of the population and again, only five percent on Medicaid, with twenty-three percent remaining uninsured.[101] In stark contrast, El Paso County shows that only thirty-two percent of the population has private coverage, sixteen percent of the population depends on Medicaid for healthcare and thirty-five percent remain uninsured.[102]

Closely related to the payor-mix is the shortage of healthcare providers in certain geographical areas. The fact remains that the border region has lower numbers of healthcare providers in proportion to the population of each respective city.[103] Examining the number of primary care physicians in each county, Webb County only had 92 providers, El Paso County was the second lowest at 308, Hidalgo County had 338, Travis County had 756, Tarrant County had 1,059, Bexar County had 1,093, Dallas County had 1,838, and Harris County had 2,766 providers.[104] Yet, even still, an analysis of the number of primary care physicians available for every

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99. ELIZABETH DALTON, INST. FOR POL'Y & ECON. DEV., UNIV. OF TEX. AT EL PASO, HEALTHCARE ACCESS ISSUES IN EL PASO COUNTY: A WORKING BLUEPRINT 4 chrt.1 (2002), http://iped.utep.edu/IPED%20Reports/2002_03PDF/report.pdf.

100. *Id.* at 4 chrt.2.

101. *Id.* at 5 chrt.3.

102. *Id* at 5 chrt.4.

103. *Id.* at 12 tbl.2.

104. DALTON, supra note 99, at 12 tbl.2

100,000 persons further exemplifies the significance of the disparity. The ratios of primary care physicians per 100,000 population by county are as follows: El Paso 38.7, Webb 47.3, Hidalgo 59.8, Tarrant 66.8, Bexar 78.3, Dallas 81.9, Harris 81.9, and Travis 114.3.[105] The three counties with the lowest physician-patient ratios are all located on the United States-Mexico border.[106]

Reality dictates that certain geographical areas will always have a higher number of patients dependent upon public healthcare coverage. For that reason, the federal government established Disproportionate Share Hospitals (DSH), which recognize and address those areas that require greater financial assistance. The majority of DSH patients fall within the socio-economic status of low-income, thus the federal government assists such hospitals to compensate for their loss of income by serving that population.[107] In Texas, there are three cities that have acquired permanent DSH status: Galveston, Tyler, and Houston.[108] The remainder of hospitals in the state must annually re-qualify for the extra assistance.[109] It is important to note that counties in the direst and most severe of positions, resulting from high numbers of uninsured, high numbers of Medicaid recipients, and the lowest ratios of healthcare providers, are denied permanent status as Disproportionate Share Hospitals.

The financial strain upon providers would not be as severe if the rate of reimbursement was adequate and essentially equitable across the state. The solution to the problem is equity and adequacy in the administration of the Medicaid program. Thus, providers who are denied equal rates or reimbursement are in the best position to assert the rights of their patients within the judicial system.

III. LEGAL ANALYSIS

Irrespective of which cause of action is employed to sue the State of Texas, courts should recognize and allow Medicaid beneficiaries' claims to be brought by their physician-providers. A number of claims have been previously explored in other notes and comments. The primary focus of this comment, however, is on a claim arising under the Equal Access Clause of the Medicaid Act, specifically under 42 U.S.C. § 1983; a civil action for deprivation of rights under color of law. In fact, case law determined by the Fifth Circuit Court of Appeals has already recognized that Medicaid beneficiaries have a private right of action under the

105. *Id.* at 12 tbl.2.
106. *Id.*
107. TEX. HEALTH AND HUMAN SERV. COMM'N, *supra* note 11, at G8.
108. Figueroa, *supra* note 20, at 61.
109. *Id.*

Act.[110] Courts, however, have not directly ruled on whether physician-providers can assert a cause of action to sue in the capacity as next friend of a Medicaid beneficiary against the Texas Department of Health and Human Services Commission in order to enforce the Equal Access Clause in the Medicaid Act. It should be noted, however, that several cases have come within close proximity of specifying the scope of a physician's third-party standing in Medicaid cases.

Initially, the United States Supreme Court acknowledged physicians' right to assert the rights of their patients in *Singleton v. Wulff.*[111] However, *Singleton* involved a right to privacy, specifically, a woman's right to have an abortion. Third-party standing has yet to be extended to other physician-patient relationships.

There is a split of authority among the Federal Circuit Courts as to whether healthcare providers themselves have standing to sue state governments. The First,[112] Sixth,[113] Eighth[114] and Tenth[115] Circuit Courts have ruled in favor of recognizing that providers have standing on behalf of their patients. In contrast, the Third[116] and Fifth[117] Circuit Courts expressly refused to acknowledge a provider's private right of action. In *Pennsylvania Pharmacists Association v. Houston,*[118] the Third Circuit ruled that pharmacists could not assert their own rights to enforce the Medicaid Act.[119] Similarly, the Fifth Circuit Court of Appeals, in *Evergreen Presbyterian Ministries v. Hood,* ruled that healthcare providers are not entitled to sue in their own individual capacity, claiming their own rights under the Medicaid Act. The court reasoned that Congress, in passing the 1997 Balanced Budget Act and repealing the Boren Amendment, discussed *infra,* did not intend for providers to be beneficiaries under the Act.[120]

Yet, the *Evergreen* court specifically held that the Act intended to provide coverage for Medicaid recipients, effectively limiting standing to

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110. Evergreen Presbyterian Ministries Inc. v. Hood, 235 F.3d 908 (5th Cir. 2000).

111. Singleton v. Wulff, 428 U.S. 106 (1976) (holding physicians stood in an intimate relationship with the patient's right to have an abortion).

112. Visiting Nurse Ass'n v. Bullen, 93 F.3d 997 (1st Cir. 1996).

113. Westside Mothers v. Haveman, 289 F.3d 852 (6th Cir. 2002).

114. Arkansas Med. Soc'y v. Reynolds, 6 F.3d 519 (8th Cir. 1993); Pediatric Specialty Care Inc. v. Arkansas Dep't of Human Serv., 364 F.3d 925, 930 (8th Cir. 2004).

115. Amisub, Inc. v. Colorado Dep't of Soc. Serv., 879 F.2d 789 (10th Cir. 1989).

116. Pa. Pharmacists Ass'n v. Houstoun, 283 F.3d 531 (3d Cir. 2002) (finding that the Medicaid Act does not identify physicians as intended beneficiaries).

117. Evergreen Presbyterian Ministries Inc. v. Hood, 235 F.3d 908 (5th Cir. 2000).

118. *Pa. Pharmacists Ass'n*, 283 F.3d 531 (3d Cir. 2002).

119. *See generally* Recent Case, *Health Care Law – Medicaid – Third Circuit Finds Providers Lack Standing To Enforce the Medicaid Act*, 116 HARV. L. REV. 969 (2003).

120. *Evergreen*, 235 F.3d at 929.

beneficiaries and their individual entitlement to equal access to medical care.[121] Therefore, the specific question raised in this comment has yet to be addressed by the courts.

A. *The Boren Amendment.*

Congress passed the Boren Amendment to the Medicaid Act in 1980, transferring authority to ensure reimbursement to physician-providers from the federal government to the state governments.[122] State governments became responsible for ensuring compliance with federal standards in the payment plan of administering the Medicaid Act within the state.[123]

While the intent of Congress was to remove federal oversight of state payment plans, the effect was a shift of executive oversight to federal judicial review.[124] Previously, federal courts held that the Boren Amendment specifically conferred enforceable rights to physician-providers, not only to the Medicaid beneficiaries, and that the Civil Rights Act, 42 U.S.C. § 1983 was the legal avenue through which enforcement was asserted.[125] In 1997, the Balanced Budget Act effectively repealed the Boren Amendment as well as physician-providers' right to enforcement of the Medicaid Act.[126] Medicaid providers cannot sue under the Act to enforce their own rights, however there has been no ruling specifically prohibiting physicians to use their resources to assert the rights and causes of action of patients.

B. *Civil Action for Deprivation of Rights 42 U.S.C. § 1983*

As a legal avenue through which enforcement of the Medicaid Act can be asserted, 42 U.S.C. § 1983 states:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be

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121. *Id.* at 927.
122. *See* Harkins, *supra* note 24, at 159.
123. *See id.* at 169.
124. *See id.* at 178.
125. *See id.* at 179.
126. *See id.* at 159.

granted unless a declaratory decree was violated or declaratory relief was unavailable.[127]

Section 1983 was first enacted as part of the Civil Rights Act of 1871. The controversy over the statute was whether or not the rights protected in section 1983 were limited to constitutional violations. There was a split among the justices as to whether or not the amended phrase "and laws" was inclusive of statutory rights.[128] Prior to 1980, section 1983 suits were only permitted where there was a violation of a constitutionally protected right.[129] Yet, in *Chapman v. Houston Welfare Rights Organization*,[130] Justice Powell interpreted the language to mean "and laws providing for equal rights."[131] That interpretation effectively allowed section 1983 to be utilized as an effective tool for the enforcement of entitlement programs. The controversy was finally decided in *Maine v. Thiboutot*,[132] when the Court recognized the right of individuals to bring suit on statutory claims.[133]

The Supreme Court's progression toward a narrow interpretation of section 1983, led by Chief Justice Rehnquist, was discussed in great detail by Bradford C. Mank in his article on the effects of *Gonzaga University v. Doe*.[134] Prior to the United States Supreme Court's decision in *Gonzaga*, plaintiffs frequently brought suit against state actors under 42 U.S.C. § 1983 for inequitable and inadequate administration of federal spending programs.[135] *Gonzaga* effectively brought an end to such lawsuits by shifting the burden of proof onto the private plaintiff to demonstrate Congress' clear intent to allow for a private right of action.[136] The Supreme Court's opinion mandates that the plaintiff prove that the act under which the claim is brought not only identifies the plaintiff as the individual class to be directly benefited, but also that Congress intended for the act to grant those beneficiaries specific, individual and enforceable rights. Chief Justice Rehnquist's majority opinion states, "We made clear that unless Congress 'speaks with a clear voice,' and manifests an 'unambiguous' intent to confer individual rights, federal funding provisions pro-

127. Civil Action for Deprivation of Rights, 42 U.S.C. § 1983 (2004).

128. Bradford C. Mank, *Suing Under § 1983: The Future After Gonzaga University v. Doe*, 39 HOUS. L. REV. 1417, 1429 (2003).

129. *Id.* at 1427.

130. Chapman v. Houston Welfare Rights Org., 441 U.S. 600 (1979).

131. Mank, *supra* note 128, at 1429.

132. Maine v. Thiboutot, 448 U.S. 1 (1980).

133. Mank, *supra* note 128, at 1430.

134. *See generally id.*

135. *See id.* at 1440, accord Figueroa, *supra* note 20, at 63.

136. Mank, *supra* note 128, at 1420.

vide no basis for private enforcement by section 1983."[137] Even when a federal act speaks directly to an identified class of beneficiaries, the Court will refuse to find a basis for private enforcement when the act "[confers] no specific, individually enforceable rights."[138]

A two part test was developed in *Golden State Transit Corp. v. City of Los Angeles*,[139] and later refined in *Blessing v. Freestone*[140] to assist courts in determining whether federal rights are enforceable using section 1983.

> First, Congress must have intended that the provision in question benefit the plaintiff. Second, the plaintiff must demonstrate that the right assertedly [sic] protected by the statute is not so "vague and amorphous" that its enforcement would strain judicial competence. Third, the statute must unambiguously impose a binding obligation on the States. In other words, the provision giving rise to the asserted right must be couched in mandatory, rather than precatory, terms.[141]

The *Blessing* Court placed greater emphasis on the necessity of determining congressional intent. If the Court finds that Congress actually intended to prohibit certain remedies, the case will nonetheless be dismissed even where it has been proven that the federal statute created a right.[142]

One of the two exceptions to the Supreme Court's narrow view in *Blessing* was the decision in *Wilder v. Virginia Hospital Association*,[143] which allowed a hospital district to successfully sue to force the state to adopt "reasonable and adequate" reimbursement rates under section 1983.[144] It is important to note that the Boren Amendment to the Medicaid Act was crucial to the Court's decision. As such, no similar decisions have been handed down since the congressional repeal of the amendment. However, for the purpose of this analysis, the Fifth Circuit has already set forth the rights of Medicaid recipients using a three-step standard.

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137. Gonzaga Univ. v. Doe, 536 U.S. 273, 280 (2002).

138. *Id.* at 281.

139. Golden State Transit Corp. v. Los Angeles, 493 U.S. 103, 106 (1989) (creating a two prong test for enforcement of rights through § 1983).

140. Blessing v. Freestone, 520 U.S. 329 (1997).

141. *Id.* at 340-41.

142. *Id.* at 341 (arguing for dismissal where Congress specifically foreclosed a remedy under § 1983).

143. Wilder v. Va. Hosp. Ass'n, 496 U.S. 498 (1990).

144. *Id.* at 524.

C. *Medicaid Suits in Texas*

In Texas, *Evergreen* controls any inquiry into which actors have a private right of action against the State of Texas for the enforcement of rights through the Medicaid Act.[145] In *Evergreen*, two individual recipients and their provider nursing homes sued the State of Louisiana. While the *Evergreen* court refused to find that the Medicaid Act directly benefited healthcare providers, it specifically found that 42 U.S.C. § 1396a(a)(30)(A) was "'phrased in terms' benefitting [sic] recipients in that it directly focuses on their access to medical care."[146] The court stated, "Indeed, section 30(A) speaks clearly in terms of the recipients because 'care and services are [to be] available under the [state] plan at least to the extent that such care and services are available to the general population in the geographic area.'"[147]

Commentary distinguished older case law from current interpretation on Medicaid cases based on the language in section 30(A) that does not directly address costs to providers, but instead focuses on beneficiaries.[148] The Boren Amendment was crucial to previous suits because it included language directly beneficial to healthcare providers; in its absence, courts have refused to recognize a provider's right to assert a cause of action.[149]

While the *Evergreen* holding was handed down before *Gonzaga*, it is still good law in the Fifth Circuit. This is because similar language used in the analysis mirrors the conclusion that Medicaid recipients have an individual entitlement under section 1983, which affords them the right to bring suit under the color of law statute.

The *Evergreen* court also examined the term "geographic area" and stated, "we understand that the phrase 'geographic area' could have many definitions depending upon the type of service or the needs of recipients in a particular area."[150] The court's interpretation of "geographic area" appears to be amenable and flexible to the facts of each case, since the definition of "geographic area" depends upon individual "needs."

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145. Evergreen Presbyterian Ministries, Inc. v. Hood, 235 F.3d 908 (5th Cir. 2000).

146. *Id.* at 927.

147. *Id.* (quoting 42 U.S.C. § 1396a(a)(30)(A)).

148. Recent Case, *supra* note 119, at 971-72.

149. *See* Meredith Warner Nissen, *Issues in the Third Circuit: Pharmacists Without Remedies Means Serious Side Effects for Patients: Third Circuit Denies Pennsylvania Pharmacists Standing to Challenge Reimbursement Rates Under the Medicaid Act*, 48 VILL. L. REV. 1377, 1382 (2003).

150. *Evergreen*, 235 F.3d at 931.

D. *The Physician Exception to Third-Party Suits*

No court has yet recognized third-party standing for physician-providers to enforce the Medicaid Act. There are only a few instances where the Supreme Court has addressed the issue of third-party standing.[151] The United States Supreme Court extended third-party standing to physician-providers, but only in abortion cases where a woman's right to choose was affected.

Undeniably, standing is a fundamental concern of each case, as courts will not address the merits of any controversy until standing has been properly asserted and established.[152] Furthermore, on a motion to dismiss for want of standing, trial courts and appellate courts are required to construe the allegations and the complaint itself in a light most favorable to the complaining party.[153] "At the same time, it is within the trial court's power to allow or to require the plaintiff to supply, by amendment to the complaint or by affidavits, further particularized allegations of fact deemed supportive of the plaintiff's standing."[154] In light of these holdings, the issue of standing is determined in a case-specific fact inquiry. As long as the physician-provider, as the plaintiff, can substantiate and satisfy the requirements of standing, the suit should proceed to the merits of the case. In cases challenging the Medicaid Act, the physician-provider can overcome that burden.

According to the resources and information available, physician-providers are in a much better position than Medicaid patients to sue for enforcement of the Medicaid Act.[155] The relationship that exists between physician-providers and Medicaid beneficiaries is close enough that any extension of third-party status upon physician-providers for the enforcement of the Medicaid Act is not only probable, but logical.

The Supreme Court enumerated two reasons for disfavoring suits brought by parties who are "next friends" of those whose rights are being asserted.[156] The Court articulated the general rule in *Singleton v. Wulff*,[157] "[o]rdinarily, one may not claim standing in this Court to vindi-

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151. *See* David J. Oliveiri, Annotation, *Requirements of Article III of Federal Constitution as Affecting Standing to Challenge Particular Conduct as Violative of Federal Law – Supreme Court Cases*, 70 L. Ed. 2d 941, 961-63 (1983 & Supp. 2004).

152. *See id.* at 946 ("The Supreme Court has also held that it is obliged as a matter of the 'case or controversy' requirement associated with Article III of the Constitution, in reviewing a decision of a federal district court, to examine the standing of the parties even if the issue of standing is not raised by the parties themselves.").

153. Warth v. Seldin, 422 U.S. 490, 501 (1975); *see also* Oliveiri, *supra* note 151, at 946.

154. *Warth*, 422 U.S. at 501.

155. Recent Case, *supra* note 119, at 970.

156. *See* Singleton v. Wulff, 428 U.S. 106, 114 (1976).

157. *Singleton*, 428 U.S. 106.

cate the constitutional rights of some third party."[158] First, the court believes that those who hold a right to sue may not "wish to assert them, or will be able to enjoy them regardless of whether the in-court litigant is successful or not." Second, the party asserting the rights of another will be a better and most effective advocate of their own rights.[159]

However, there are cases in which the Supreme Court acknowledged a physician's right to assert a claim on behalf of his or her patients.[160] Even though the facts specific to such cases have only involved reproductive rights, the court's analysis focused upon the injury directly caused upon the physician. Therefore, the main argument of this comment finds support in the fact that the Court allows third-party standing because of the nature of the physician-patient relationship.

The United States Court of Appeals for the Fifth Circuit directly ruled upon third-party standing in favor of the physician provider in *Okpalobi v. Foster*.[161] Citing *Singleton v. Wulff*, the *Okpalobi* court noted two preliminary requirements to establish standing: injury in fact; and standing to enforce their patients' constitutional rights.[162]

Okpalobi restated the three elements which plaintiffs must allege: "(1) an injury that is concrete, particularized and actual or imminent; (2) a causal connection between the alleged injury and the defendant's conduct; and (3) a likelihood that a favorable decision will redress the injury."[163] At the same time, the court acknowledged the well-established law that a claim of "direct economic harm," specifically to physicians who perform abortions, satisfied this requirement.[164]

Then, the court turned to an analysis of third-party standing, and recognized that the Supreme Court created an exception to the general rule disfavoring third party plaintiffs in circumstances of physicians asserting the reproductive rights of their patients.[165] Utilizing the framework established in *Singleton*, this examination required the presence of two elements. The first element involved the consideration of the relationship between the litigant and the person whose rights were being asserted. Analysis of the first element was explained by the court:

> If the enjoyment of the right is inextricably bound up with the activity the litigant wishes to pursue, the court at least can be sure that its

158. *Id.* at 114 (citing Barrows v. Jackson, 346 U.S. 249, 255 (1953)).
159. *Id.*
160. Oliveiri, *supra* note 151, at 961-63.
161. Okpalobi v. Foster, 190 F.3d 337 (5th Cir. 1999).
162. *Id.* at 350-51.
163. *Okpalobi*, 190 F.3d at 350.
164. *Id.*
165. *Id.* at 351 (citing Singleton v. Wulff, 428 U.S. 106, 114 (1976)).

> construction of the right is not unnecessary in the sense that the right's enjoyment will be unaffected by the outcome of the suit.[166]

Next, the court looked to whether there existed "some genuine obstacle preventing the third party from asserting her own rights."[167] The simple fact that patients are enrolled in the Medicaid program demonstrates a lack of resources to receive basic healthcare. Logically, these patients have a substantial obstacle to access legal representation to assert their rights.[168]

In *Diamond v. Charles*,[169] the Supreme Court articulated that a provider who shows that "funding regulations have a direct financial impact on his practice may assert the constitutional rights of other individuals who are unable to assert those rights themselves."[170] The Court, however, rejected the argument in *Diamond* because of the speculative nature of the pediatrician's claim that enforcement of abortion laws would increase his patient population. In effect, the Court noted that in order to recover, the party must have sustained a "concrete injury" in order to distinguish between a party with an interest in the "direct outcome of a litigation" rather than a party "with a mere interest in the problem."[171]

While this comment acknowledges the important differences between a woman's right to have an abortion and an indigent person's access to healthcare, both individuals possess the right of confidentiality within the patient-physician relationship. The Fifth Circuit opinion compared the provider in *Okpalobi* to the provider in *Singleton* and determined that the lack of distinction between the two could only allow a logical conclusion to grant standing in that case.[172] Emphasis was placed upon the relationship of the patient-provider, and the decision was handed down on grounds that the patient could not assert his or her constitutional right without the assistance of his or her physician.[173] Such a conclusion provides the best argument for a physician-provider's assertion of rights of Medicaid beneficiaries.

The federal legislature has bestowed an entitlement to indigent persons to receive medical care. That same right has been recognized by the Fifth Circuit, applying the Supreme Court's standard, when the Fifth Circuit

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166. *Id.*

167. *Id.*

168. *See* Fresithler, *supra* note 41, at 1415-16 (explaining the indigent face a heightened difficulty to pay for legal fees).

169. Diamond v. Charles, 476 U.S. 54 (1986).

170. *Id.* at 65-66 (rejecting the claim of the physician who claims interest in his status as a doctor because the relationship to his patients were too attenuated and speculative).

171. *Id.* at 66-67 (quoting United States v. SCRAP, 412 U.S. 669, 687 (1973)).

172. *Okpalobi*, 190 F.3d at 351.

173. Singleton v. Wulff, 428 U.S. 106, 118 (1976).

explicitly held that the Medicaid Act designates that the enrollees, and not the physicians, are the intended beneficiaries of the program. The court specifically determined that Congressional intent granted beneficiaries the right to enforce the Medicaid Act through section 1983.[174] Furthermore, Medicaid patients rely and depend upon the discretion of physician-providers to facilitate their right to receive medical attention. Therefore, logical progression leads to the conclusion that physicians also have third-party standing to assert the rights of Medicaid beneficiaries, just as they have been allowed to assert the rights of their female patients seeking reproductive freedom.

IV. CONCLUDING REMARKS

The greatest loss is placed upon the shoulders of the indigent of this nation. The recent budget cuts made by the Texas Legislature impact children more than any other class of persons.[175] This pattern of cost-saving techniques is disheartening, especially in light of the fact that while children make up the largest portion of Medicaid enrollees, they only comprise a mere nineteen percent of total expenditures.[176] The indigent and the children of this nation are the ultimate losers in the budgetary games played by the legislature, notwithstanding the fact that they are the very people the Medicaid Act was designed to protect. When the State of Texas inequitably administers the Medicaid program and further reduces budgetary appropriations, the state effectively reduces the number of physician-providers attending the indigent sick, and denies Medicaid beneficiaries medical care. The ultimate result is a system engendered to withhold healthcare services and prevent the enforcement of the entitlement program by limiting the scope of the indigent's cause of action. The Fifth Circuit dissolved a legal remedy previously-afforded to the physician-providers, who are best equipped to enforce the Act through the judiciary.

While Medicaid recipients are afforded the right to bring a cause of action on their own, it is very unlikely a suit will be filed. Although the right to enforce the Medicaid Act is available, it is an unlikely solution for recipients who lack legal resources to utilize judicial remedies. Individuals who qualify for Medicaid do so because they have no resources to access medical attention; it is logical to conclude that they also lack resources to access the courts. However, an alternative that would give a

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174. *Okpalobi*, 190 F.3d at 351.

175. *See generally*, DUNKELBERG & O'MALLEY, *supra* note 67, at 6; HILL, *supra* note 8.

176. KAISER COMM'N ON MEDICAID AND THE UNINSURED, *supra* note 27, at tbl."Medicaid Enrollment vs. Spending".

voice to the voiceless is available: allowing physician-providers to sue on behalf of their Medicaid eligible patients.

As stated earlier, the courts have already recognized third-party standing for physicians in abortion rights causes of action. The courts should now recognize the same relationship between physicians and their Medicaid patients. The two relationships parallel each other in that both classes of patients seek to exercise a right and both stand in a dependent position upon their physician to exercise that right for them. Moreover, this comment demonstrates the existence of an injury to Medicaid physician-providers as well. These physicians have a direct stake in the litigation; for without equitable reimbursement, financial failure is certain. Furthermore, empirical evidence indicates a causal relationship between the inevitable injury suffered by Medicaid physician-providers and the denial of equitable reimbursement rates. Should the courts simply rule in favor of enforcement of the Equal Access Clause of the Medicaid Act, the physician-providers would be afforded a legal remedy for the unfair and inequitable administration of the Medicaid Act.

Therefore, it follows from this analysis that the law should extend third-party standing to healthcare providers whom Medicaid recipients depend upon, to stand in place of the recipients asserting their rights to enforce the Medicaid Act.